		FORM APPROVED OMB NO. 0938-019
	1. TRANSMITTAL NUMBER:	2. STATE:
TRANSMITTAL AND NOTICE OF APPROVAL OF	9 7 — 0 4	Missouri
STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TI SECURITY ACT (MEDICAID)	TLE XIX OF THE SOCIAL
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE June 13, 1997	
5. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CO	NSIDERED AS NEW PLAN	AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	NDMENT (Separate Transmittal for each a	mendment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
42 CFR	· · · ·	13,504
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	b. FFY 98 \$ 9. PAGE NUMBER OF THE SUPERS	9,024 SEDED PLAN SECTION
Attachment 4.19A	OR ATTACHMENT (If Applicable): Attachment 4.19A	
Pages 10d, 18., 11,12,18, 19, 20, 21 & 32	Pages 10d, 11, 12, 18,	19, 20, 31 & 32
allocated to Managed Care program for first tie		d recipients
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT ACCOMMENTS OF GOVERNOR'S OFFICE ENCLOSED	□ OTHER, AS SPECIFIED:	recipients
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT of COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	_	1 recipients
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT OF COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	_	1 recipients
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL:	OTHER, AS SPECIFIED:	1 recipients
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME:	OTHER, AS SPECIFIED:	
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S	
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE:	OTHER, AS SPECIFIED:	
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court	Services
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: 6-27-97 FOR REGIONAL OF	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court Jefferson City, MO	Services
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: FOR REGIONAL OF	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court Jefferson City, MO FICE USE ONLY 18. DATE APPROVED:	Services
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: FOR REGIONAL OF 17. DATE RECEIVED: 06/30/97	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court Jefferson City, MO FICE USE ONLY 18. DATE APPROVED: AUG 28 2001	Services
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: FOR REGIONAL OF 17. DATE RECEIVED: 06/30/97	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court Jefferson City, MO FICE USE ONLY 18. DATE APPROVED:	Services 65109
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: FOR REGIONAL OF 17. DATE RECEIVED: 06/30/97 PLAN APPROVED - COMMENT	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical Section Court Jefferson City, MO FICE USE ONLY 18. DATE APPROVED: AUG 28 2001 NE COPY ATTACHED 20. SIGNATURE OF REGIONAL OFFICIAL	Services 65109
11. GOVERNOR'S REVIEW (Check One): GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL 12. SIGNATURE OF SCATE AGENCY OFFICIAL: 13. TYPED NAME: Gary J. Stangler 14. TITLE: Director, Department of Social Services 15. DATE SUBMITTED: FOR REGIONAL OF 17. DATE RECEIVED: 06/30/97 PI AN APPROVED - C	OTHER, AS SPECIFIED: 16. RETURN TO: Division of Medical S 615 Howerton Court Jefferson City, MO FICE USE ONLY 18. DATE APPROVED: AUG 28 2001	Services 65109

23. REMARKS:

Namette Foster Reilly

SPA CONTROL

Date Submitted 06/27/97
Date Received 06/30/97

- 4. As determined from the third prior year desk reviewed cost report, the hospital has -
- (a) An unsponsored care ratio of at least sixty-five percent (65%); or
- (b) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors.
- 5. As determined from the third prior year desk reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.
- B. Those hospitals which meet the criteria established in paragraphs (VI) (A)I., 2. and 4. shall be deemed first tier ten percent (10%) Add-on disproportionate share hospital (DSH). Those hospitals which meet the criteria established in (VI)(A)I. and 3. shall be deemed first tier DSH. Those hospitals which meet only the criteria established in paragraphs (VI)(A)1. and 2. or (VI)(A)1. and 5. shall be deemed Second Tier DSH.
- C. Disproportionate Share Hospital Rates will be determined as follows:
 - 1. Data from the most recently desk-reviewed cost report for the latest fiscal period preceding the rate determination date will be used to determine a rate in accordance with the following formula subjected to the adjustments described in paragraph VI.B.3.

Per Diem Rate =
$$\frac{OC}{MPD}$$
 + $\frac{CMC}{MPDC}$

- (a) OC-the operating component is the hospital's total allowable cost less CMC. Only the operating component will be increased by the trend indices for the current and first prior fiscal year.
- (b) CMC-the capital and medical education components of the hospital's total allowable cost;
- (c) MPD-the number of Medicaid inpatient billed days for service dates in the applicable cost report period;
- (d) MPDC MPD as defined previously with a minimum utilization of sixty percent as described in paragraph V.C.4; and
- (e) An additional increase of ten percent (10%) will be added to the rate if the facility is first tier ten percent (10%) Add-on.

State Plan TN# 97-04 Supersedes TN# 94-22 Effective Date ___lune 13, 1997 Approval Date ___AUG 2 8 2001

- 2. First tier disproportionate share hospitals shall be exempt from length of stay limits except as they apply to GR recipients. Allowable days for claim payment will be the medically necessary billed days of service for which the patient was Medicaid-eligible.
- 3. All estimated disproportionate share payments for each hospital determined as the product of the applicable disproportionate share rate per subsection VI.C. times allowable days for claim payment per agency determination will be compared against the minimum payment amounts per federal regulations. The disproportionate share will not be subject to the Medicare rate limitation.
 - (a) The federal minimum payment per-diem rate, not to exceed the Medicare rate will be the general plan per-diem plus a percentage determined as the greater of-
 - (1) One-half (1/2) the amount by which the provider's Medicaid inpatient utilization rate, as described in subparagraph VI.A.2.(b)(1), exceeds the sum of the state's mean Medicaid inpatient utilization rate plus one (1) standard deviation; or
 - (2) Two and one-half percent (2.5%)
 - (b) The federal minimum payment amount for the facility will be determined as the product of the federal minimum payment per-diem rate, as established in subparagraph VI.B.(3)(a), times the allowable days for claim payment per program benefit limitations as determined by the Division of Medical Services.
 - (c) If the federal minimum payment amount in subparagraph VI.B.3.(b) exceeds the disproportionate share payments as determined in paragraph VI.B.3. the provider's Missouri Medicaid disproportionate share per diem rate shall be adjusted to a level at which the federal minimum payment amount equals the rate multiplied by the applicable number of days.
- 4. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.
- 5. Disproportionate share hospitals which qualify as first tier ten percent (10%) add-on hospitals shall not have their disproportionate share rate reduced below the disproportionate share rate in effect on June 30, 1991.

Attachment 4.19A Page 12

- D. OBRA 93 Limitation. In accordance wit OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The OBRA 93 Limitation shall be computed using the third prior year desk reviewed cost report trended thru the current State Fiscal Year and adjusted for MC+ implementation as defined in Section XVII. If the sum of disproportionate share payments exceeds the estimated OBRA 93 limitation, the difference shall be deducted in order as necessary from the safety net payment, other disproportionate share lump sum payments, and if necessary, as a reduced per diem.
- E. Hospitals which qualified as disproportionate share for SFY 94 and which failed to requalify as disproportionate share for SFY 95 shall be granted disproportionate share status effective January 1, 1995 provided the hospital meets the minimum 1% Medicaid inpatient utilization rate required by the Omnibus Budget Reconciliation Act of 1994. Disproportionate share status shall be at the same level (Tier I or Tier II) which the hospital qualified for during SFY 94. This waiver shall not continue for any admissions after June 30, 1995.

- The safety net adjustment shall be equal to the lesser of CC charges or total unreimbursed hospital charges. Unreimbursed hospital charges are computed as THC less patient revenues and UCACI adjustments computed in accordance with subsection XV.A. In the case of nominal charge providers whose total charges are less than cost, total hospital costs shall be substituted for THC;
- If the aggregate (CS) are less than the matching amount required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.
- 3. The data sources, reports and data definitions for determining the Safety Net Adjustments shall be the same as described in paragraph VI.A.2. and adjusted as may be described above. Hospitals which do not have a third prior fiscal year cost report described in paragraph VI.A.2. shall not be eligible for a safety net adjustment. No amended cost reports shall be eligible for a safety net adjustment. No amended cost reports shall be accepted after the Division's annual determination of the adjustment amount.
- 4. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.
- XVII. In accordance with state and federal laws regarding reimbursement of inpatient and outpatient hospital services and the implementation of a Medicaid managed care system, reimbursement for state fiscal year 1997 (July 1, 1996 - June 30, 1997) shall be determined as follows.
 - A. State Fiscal Year 1997 Reimbursement for Inpatient and Outpatient Hospital Services
 - Claims for inpatient and outpatient hospital services for Missouri Medicaid eligible recipients, not enrolled in a Medicaid managed care plan such as MC+, shall continue to be reimbursed in accordance with current regulations and claims processing procedures.
 - 2. Inpatient per diem rates in effect as of June 30, 1996, shall be adjusted by one-half of the trend indices applicable for state fiscal year 1995, 1996, and 1997. Per diem rates for hospitals which initially qualify July 1, 1996, as first or second tier Disproportionate Share or hospitals which previously qualified as first or second tier and failed to requalify July 1, 1996 shall be adjusted to a disproportionate share or general plan level as appropriate.

State Plan TN# <u>97-04</u> Supersedes TN # <u>96-41</u> Approval Date AUG 28 2001

3. Medicaid Add-on payments based on one hundred percent (100%) of the allocated Medicaid shortfall and ninety-nine percent (99%) of the cost of the uninsured shall be prorated over SFY 97. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive a Medicaid Add-on payment based on one hundred percent (100%) of the allocated Medicaid shortfall and one hundred percent (100%) of the cost of the uninsured.

B. Medicaid Add-Ons

- Medicaid Add-Ons for Shortfall and Uninsured are based on the estimated inpatient and outpatient cost attributable to Medicaid and the cost of the Uninsured for SFY 97 less the estimated per diem and outpatient reimbursement for SFY 97. The Add-on payments for cost of the Uninsured are not considered in the determination of inpatient recoupments described in section V.D.2.
- 2. The estimated inpatient cost for SFY 97 is based on the desk reviewed base year cost per day, trended thru SFY 97, and multiplied by the estimated inpatient days for SFY 97. The estimated outpatient cost is based on the base year outpatient cost trended thru SFY 97. The base year is the third prior fiscal year (i.e., The base year for SFY 97 is the FY 94 cost report.) The trending used to approximate SFY 97 costs shall include a utilization adjustment to account for the increased per diem cost resulting from introduction of MC+. The utilization adjustment shall be phased-out as follows: Year 1 (First full year of MC+) 100%; Year 2-67%; and Year 3 33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2-100%; Year 3-67%; and Year 4-33%.
- 3. The estimated per diem reimbursement for SFY 97 is based on the current per diem rate multiplied by the inpatient days, within benefit limitations, estimated to be paid for SFY 97. The estimated outpatient reimbursement is based on payment at ninety percent (90%) of base year cost trended thru SFY 97.
- 4. An adjustment to recognize the FRA assessment not included in the desk reviewed cost per day is also included. The FRA assessment attributable to Medicaid and Uninsured is determined by multiplying the ratio of base year Medicaid and Uninsured days to total inpatient days by the SFY 97 FRA assessment.

State Plan TN# 97-04 Supersedes TN# 96-41 Effective Date 06/13/97 Approval Date AUG 28 2001

- 5. An adjustment shall also be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region. The Add-On adjustment shall reimburse the hospital for the prorated Medicaid managed care cost in accordance with the allocation formula described in the Allocation of Medicaid Add-Ons section; and
- 6. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio from the base year cost report's desk review. The cost of the uninsured is then trended to the current year. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment; and

C. Allocation of Medicaid Add-Ons.

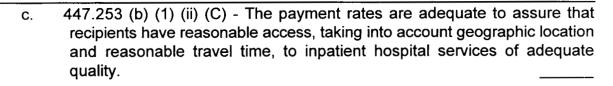
- Medicaid Add-Ons determined for Medicaid shortfall and cost of the Uninsured shall be allocated based on the estimated effect of implementation of an MC+ except as noted in paragraph XVII. C. 3. in accordance with this section. Medicaid per-diem and outpatient payments, which are paid on a claim-specific basis do not require an allocation.
- 2. Except as noted in paragraph XVII. C. 3. Medicaid Add-Ons shall be multiplied by a managed care allocation factor which incorporates, the estimated percentage of the hospitals Medicaid population which will remain outside a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual Add-On payment of \$100,000, 2) 40% of their Medicaid days are related to Medicaid recipients not eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated Medicaid Add-On is \$55,000 [(\$100,000 25%)+ (\$100,000 75% 40%)].
- The Medicaid Add-On shall not be allocated as described in paragraph XVII.C.2., therefore shall include a payment related to MC+ Medicaid the following:
 - A. The FRA assessment related to MC+; and
 - B. The Utilization Adjustment related to MC+; and
 - C. For First Tier DSH Hospitals only, any Medicaid Add-Ons related to MC+;
 - D. The Utilization and First Tier adjustment shall be phased-out as follows: Year 1 (First full year of MC+) - 100%; Year 2 - 67%; and Year 3 -33%. If applicable, an initial partial year payment will be made if MC+ is in effect less than a full state fiscal year. The phase-out will then be Year 2 - 100%; Year 3 - 67%; and Year 4 - 33%.

- XVIII. Medicaid GME Add-On--A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.
 - A. The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base year cost report and paid in quarterly installments. The base year cost report shall be the third prior fiscal year (i.e., The base year for SFY 1997 is the FY 1994 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.
 - Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital's Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars (\$100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars (\$30,000).
 - 2. The annual GME Add-On shall be paid in quarterly installments.

- XIX. Hospital Mergers. Hospitals that merge their operations under one Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.
 - 1. The Disproportionate share status of the merged hospital provider shall be:
 - A. The same as the surviving hospital's status was prior to the merger for the remainder of the State Fiscal Year in which the merger occurred: and
 - B. Determined based on the combined desk reviewed data from the appropriate cost reports for the merged hospitals' in subsequent fiscal years.
 - 2. The per diem rate for merged hospitals shall be calculated:
 - A. For the remainder of the State Fiscal Year in which the merger occurred by multiplying each hospital's estimated Medicaid paid days by its per diem rate, summing the estimated per diem payments and estimated Medicaid paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger; and
 - B. For subsequent State Fiscal Years based on the combined desk review data after taking into account the different fiscal year ends of the cost reports.
 - 3. The Medicaid Add-On for shortfall and uninsured shall be:
 - A. Combined under the surviving hospital's Medicaid provider number for the remainder of the State Fiscal Year in which the merger occurred; and
 - B. Calculated for subsequent State Fiscal Years based on the combined date from the appropriate cost report for each facility.

INSTITUTIONAL STATE PLAN AMENDMENT ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE	<u>.</u>	<u>lissouri</u>		TN - <u>97-04</u>
REIMB	URSE	MENT TYPE:	Inpatient hospital	_X
PROP	OSED	EFFECTIVE DATE:_	June 13, 1997	
A.		Assurances and Find the following findings	lings. The State assures s:	that is has
1.	of rate by effi	es that are reasonable ciently and economica applicable State and	and adequate to meet the ally operated providers to	pital services through the use ne costs that must be incurred provide services in conformity ons, and quality and safety
2.	With r	espect to inpatient ho	ospital services	
	a.	payment rates take	into account the situation	standards used to determine on of hospitals which serve a nts with special needs.
	b.	inappropriate level inpatients who requ services or interme described in section used to determine type of care must be level of care service manner consistent.	of care services (that is, sine a lower covered level of diate care services) under 1861 (v) (1) (G) of the Adaptive made at rates lower that	



- 4. 447.253 (b) (2) The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:
 - a. 447.272 (a) Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.
 - b. 447.272 (b) Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - when considered separately - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

If there are no State-operated facilities, please indicate "not applicable:"

- c. 447.272 (c) Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.
- d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act.
- B. <u>State Assurances.</u> The State makes the following additional assurances:
- 1. For hospitals
 - a. 447.253 (c) In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

	urance and Findings Certification Statement e -3-	State <u>Missouri</u> TN <u>97-04</u>
3.	447.253 (e) - The State provides for an appeals of allows individual providers an opportunity to su receive prompt administrative review, with re State determines appropriate, of payment rat	bmit additional evidence and spect to such issues as the
4.	447.253 (f) - The State requires the filing of uni participating provider.	form cost reports by each
5.	447.253 (g) - The State provides for periodic audits or records of participating providers.	of the financial and statistical
6.	447.253 (h) - The State has complied with the publi CFR 447.205.	c notice requirements of 42
	ice published on: o date is shown, please explain:	_ June 12, 1997 -
7. 4	47.253 (i) - The State pays for inpatient hospital service accordance with the methods and standards sp plan.	•
C.	Related Information	
1.	447.255 (a) - NOTE: If this plan amendment affer provider (e.g., hospital, NF, and ICF/MR; or following rate information for each provider to You may attach supplemental pages as necessity.	DSH payments) provide the ype, or the DSH payments.
	Provider Type: Hospital For hospitals: The Missouri Hospital Plan include estimated average rates. However, the DSF estimated average rates do not represent the to hospitals under the Missouri Medicaid Plan.	H payments included in the
Rev	2 (8/30/96)	

Assurance and Findings Certification Statement Page -4-		State <u>Missouri</u> TN <u>97-04</u>	
	Estimated average proposed payment rate \$ 752.90	as a result of this amendment:	
	Average payment rate in effect for the imme \$ 747.78 This rate is different than the rate special rate increase, new instate hospital	e filed with SPA 96-41 due to a	
	Amount of change: \$5.12	Percent of change:0.68%	
2. 447 (a)	.255 (b) - Provide an estimate of the short-to- long-term <u>effect</u> the change in the estimate The availability of services on a statewide a <u>This amendment will not effect the available services.</u>	ed average rate will have on: and geographic area basis:	
(b)	The type of care furnished: This ame services furnished to Medicaid eligibles.	endment will not effect hospital	
(c)	The extent of provider participation:	to account geographic location	
(d)	For hospitals the degree to which cost serve a disproportionate number of low inco It is estimated that disproportionate share had been been been been been been been bee	me patients with special needs: nospitals will receive 100% of its	